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Air Force Mental Health Before, During and Aft Deployments

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Overview

- AF Mental Health (MH) Overview
- Pre-deployment
- During Deployment
- Post-Deployment
- Revision of AF Instruction on Critical Incident Stress Management
- VA/DoD Clinical Practice Guideline (CPG) for the Management of Post-Traumatic Stress
- Linking CPG to address MH needs before, during and after deployments

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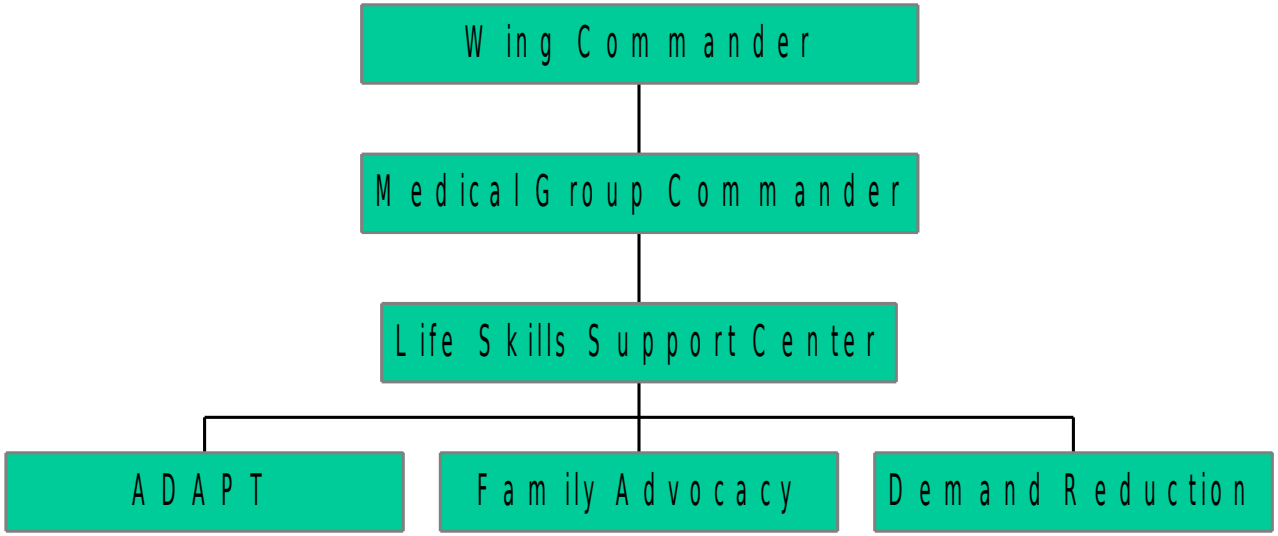
Overview (cont.)

- AF Suicide Prevention Program
- Barriers to seeking MH care
- Research Recommendations

AF Mental Health: Overview

AF Structure



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Pre-Deployment MH

- **Life-Cycle approach to health/MH readiness**
  - **MH screening occurs annually via Preventative Health Assessment process**
  - **Pre-Deployment Health Risk Assessment also screens for MH issues**
  - **Positive screening results in Life Skills or Primary Care Manager referral**
  - **MH diagnosis may lead to physical profile, which may prevent deployment until condition resolves**

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Deployment MH

- **MH prevention, consultation and intervention provided by Combat Stress Control (CSC) providers**
  - **AF has 2 standard MH deployment teams:**
    - **FFGKV: 1 psychologist, 1 social worker, 1 MH technician**
    - **FFGKU: 2 psychiatrists, 1 psychiatric nurse and 2 MH technicians**
  - **Follow precepts of DODD 6490.5 on CSC Programs**
    - **Emphasis on prevention via consultation, outreach and education**
    - **Primary, secondary and tertiary prevention methods used**
    - **use of BICEPS (brevity, immediacy, centrality, expectancy, proximity and simplicity)**

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Post-Deployment MH

- **Post Deployment Health Assessment (DD Form 2796) given**
  - **Questions 7-13 screen for MH issues**
    - **Exposure to traumatic stress**
    - **Common PTSD and depressive symptoms**
    - **Marital/family stress**
    - **Risk to self/others**
    - **Desire for help with stress related issues**
  - **Many AF MAJCOMs have reintegration protocols**
    - **Chaplains, family support and MH have teamed to devise standardized programs**
    - **Emphasis on education, communication involving member and family**
    - **AF devising service-wide reintegration protocol**

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Revision of AF Instruction (AFI) on Critical Incident Stress Management

- Current AFI heavily based on International Critical Incident Stress Foundation model
  - Recent federal guidance on management of traumatic stress have been published
  - NIMH : "*Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence, A Workshop to Reach Consensus on Best Practices*"
    - http://www.nimh.nih.gov/research/massviolence.pdf
  - VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress
    - http://www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm

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Assisting Trauma Survivors: NIMH

- Participation should be voluntary
- Key aspects of early intervention should include:
  - Basic needs
  - Psychological first aid
  - Needs assessment
  - Monitoring the recovery environment
  - Outreach and Information Dissemination
  - Fostering resilience, coping, and recovery
  - Triage
  - Treatment

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VA/DoD Clinical Practice Guideline for Traumatic Stress:

- PTSD is only part of a spectrum of traumatic stress disorders
- CPG goal: provide an algorithm to aid personnel in identifying, assessing and/or treating survivors of traumatic stress
- 5 Modules/algorithms: Core module (initial evaluation/triage), Acute Stress Reaction (ASR), Combat and Ongoing Operation Stress Reaction (COSR), Acute Stress Disorder and PTSD in Primary Care

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DoD/VA Clinical Practice Guidelines

- **Core Module**
  - **A. Use education/training to promote resiliency**
  - **B. Post trauma, screen for PTSD symptoms**
  - **C. If symptoms present, use ASR/COSR, ASD, PTSD modules**
  - **D. If there are no symptoms, provide education and access information**

DoD/VA Clinical Practice Guideline for Management of Traumatic Stress

Core Module
Initial Evaluation and Triage

Primary Prevention

Education and training to promote hardiness and resiliency [A]

Symptoms Presentation

Physical - chronic pain, migraines, vague somatic complaints
Mental - substance abuse, MDD, anxiety, or depression
Behavior - irritability, avoidance, anger or non-compliance, self risk behavior (HIV)
Evokes aversion or fear in provider
Change in function

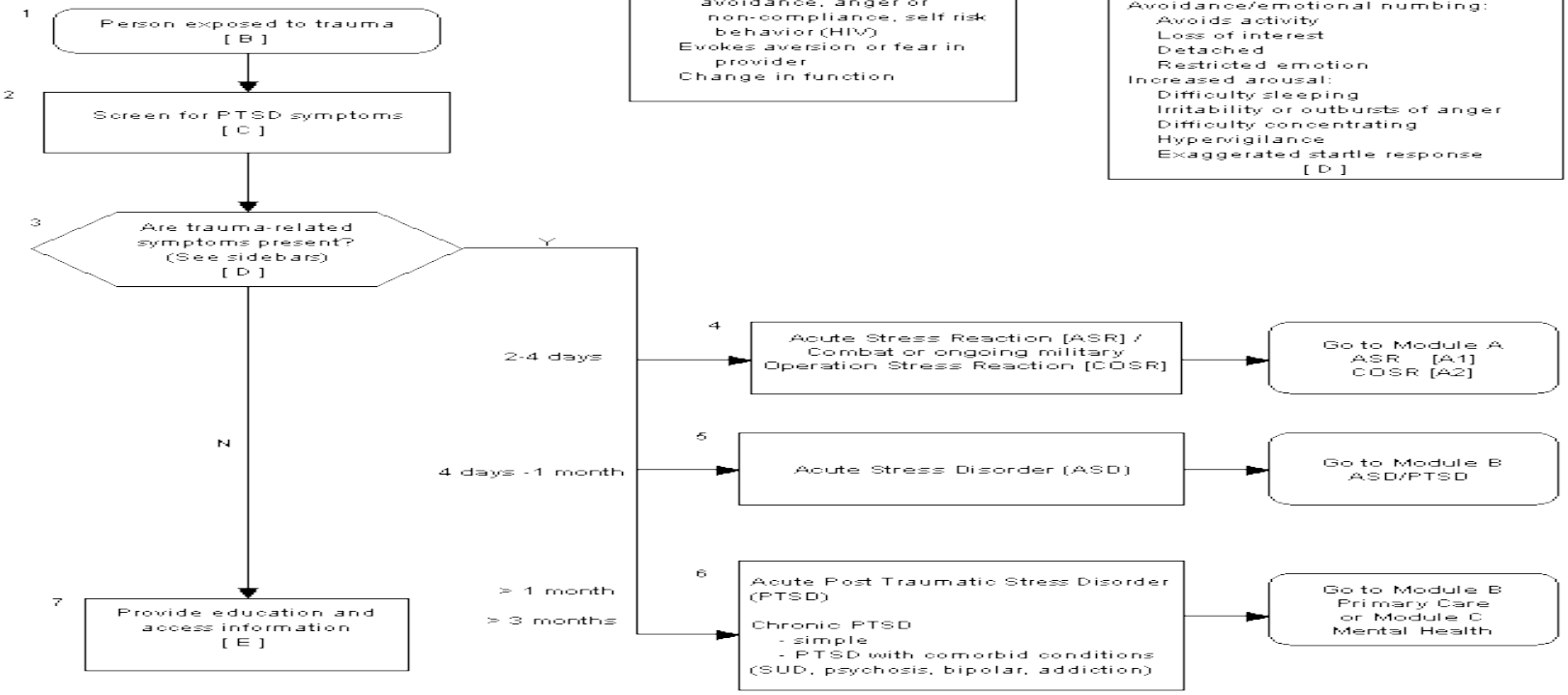
Symptom Clusters

Re-experiencing:
- Intrusive memories, images or perceptions
- Flashbacks
- Nightmares
- Exaggerated emotion and physical reactions

Avoidance/emotional numbing:
- Avoids activity
- Loss of interest
- Detached
- Restricted emotion

Increased arousal:
- Difficulty sleeping
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

[D]



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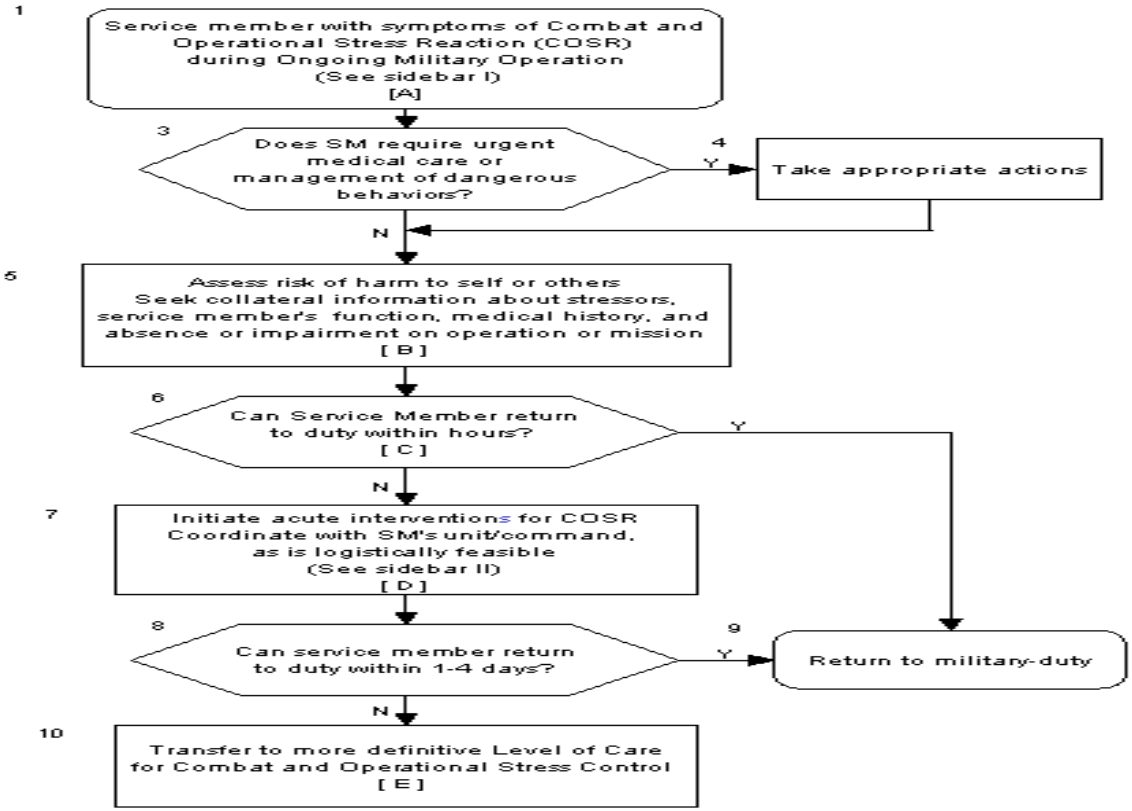
Management of Stress Reactions
Combat and Operational Stress Reaction(COSR)
During Ongoing Military Operations

A2



COSR SYMPTOMS

Possible Syndrome:
- exhaustion/burnout
- hyperarousal and anxiety
- somatic complaints (GI, GU, MS, CV, respiratory, NS)
- depression/guilt/hopelessness
- conversion disorder symptoms
- amnestic and/or dissociative symptoms
- behavioral changes
- emotional dysregulation
- anger/irritability
- brief, manageable "psychotic symptoms" (e.g., hallucinations due to sleep deprivation, mild "paranoia")

COSR does not require a specific traumatic event and can be a result of accumulating stress

COSR ACUTE INTERVENTIONS

Treat according to service member's prior role and not as a "patient"; avoid a hospital setting

Assure or provide the following, as needed:
- o Reunion or contact with primary group
- o Respite from intense stress
- o Thermal comfort
- o Oral hydration
- o Oral food
- o Hygiene (toileting, shower, shave, and female needs)
- o Sleep (to facilitate rest and restoration)
- o Encourage talk about the event with supportive others

Reserve group debriefing for members of pre-existing and continuing groups (Voluntary attendance)

Assign appropriate duty tasks and recreational activities that will restore focus and confidence and reinforce teamwork

Avoid further traumatic events until recovered for full duty

Evaluate periodically

Consider using a short course of medication targeted for specific symptoms

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Current Revision Proposal

- **Areas of consensus:**
  - **Commanders rely on a team of experts to provide consultation and services to a community in the wake of a traumatic event**
  - **The vast majority of those who are exposed to trauma will not experience long-term adverse effects**
  - **The goal of trauma intervention should be to foster resilience in those effected**
  - **Services should include: screening, education, "psychological first aid" and referral when appropriate**
  - **VA/DoD CPGs provide sound guidance on traumatic stress response**

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Recommendations

- **Recommendations for how to standardize efforts to address deployment related stress:**
  - **It may be helpful to distinguish routine deployment stress issues from traumatic stress exposure**
  - **Standardized education, screening and referral processes should be the goal**
    - **Interventions are only indicated for those screened to be symptomatic**
  - **Education, screening and referral should ideally occur before, during and after deployments, plus an additional screening 90-180 days post deployment**
  - **Public Health, MH, chaplains and family services partnership approach to education, screening and referral efforts**

Headquarters U.S. Air Force

Integrity - Service - Excellence

Air Force Suicide Prevention Program (AFSPP)

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Rates Since Implementation

- **Where we were: CY Annual Average**
  - **1987 to 1991 71.0 deaths 12.7/100K**
  - **1992 to 1996 59.8 deaths 14.3/100K**

- **Where we are: CY Annual Average**
  - **1997 to 2003 33. deaths 9.2/100K**
  - **Program fully implemented in 1997**

- **Most recent data: CY Annual Average**
  - **2003 38.0 deaths 10.2/100K**

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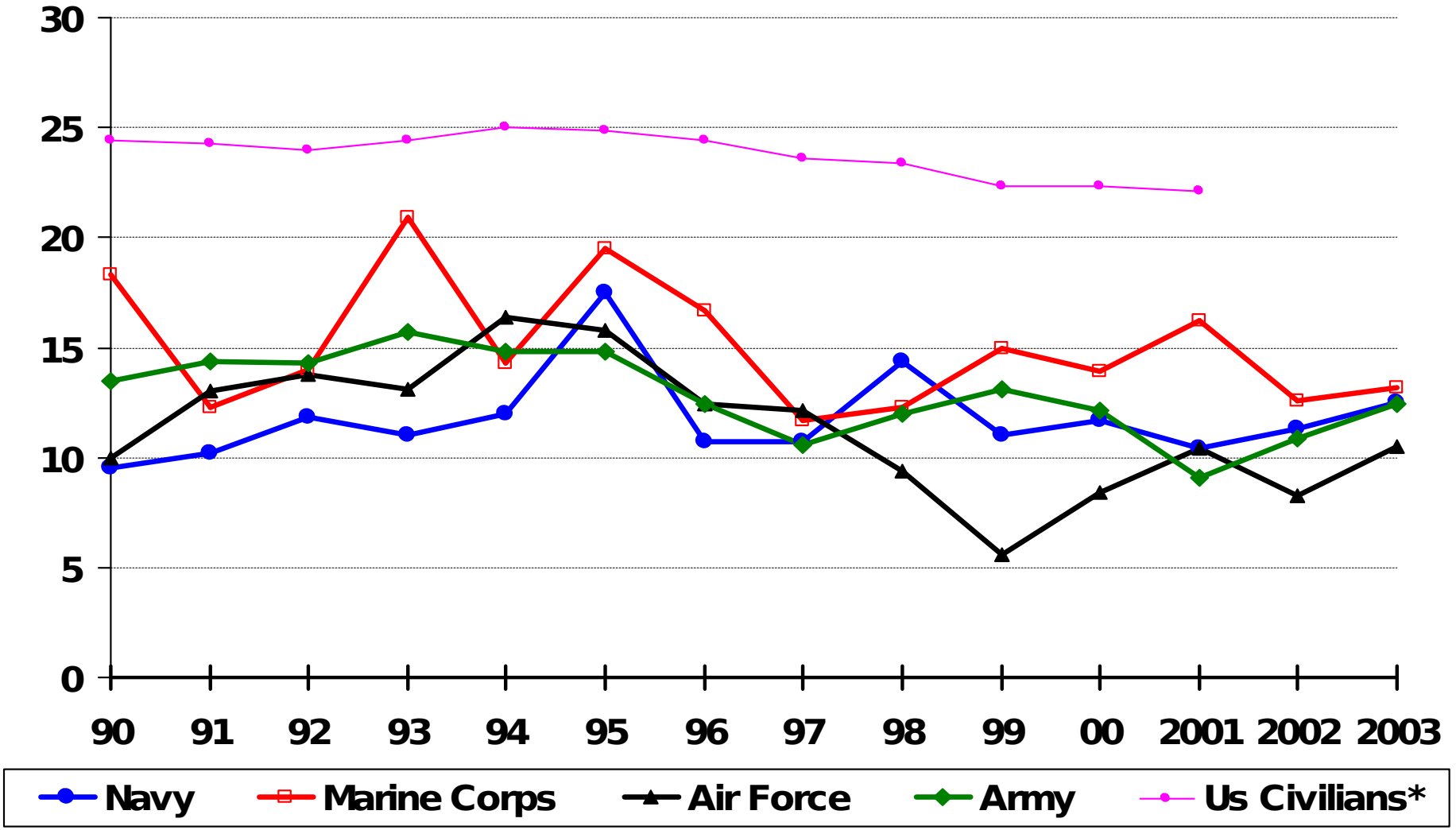
DoD CY Suicide Rates 1990-2003



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History:

11 Initiatives (AFPAM 44-160)

1. Leadership Involvement
2. Suicide Prevention in PME
3. Leaders as Gatekeepers
4. Community Prevention Services
5. Annual Suicide Prevention Training (AFI 44-154)
6. Investigative Interview Hand-Off Policy

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History: 11 Initiatives (AFPAM 44-160)

7. Critical Incident Stress Management (AFI 44-153)
8. Created Integrated Delivery System
9. Established Limited Patient-Psychotherapist Privilege (AFI 44-109)
10. Behavioral Health Survey
11. Epidemiological Database & Surveillance System (SESS)

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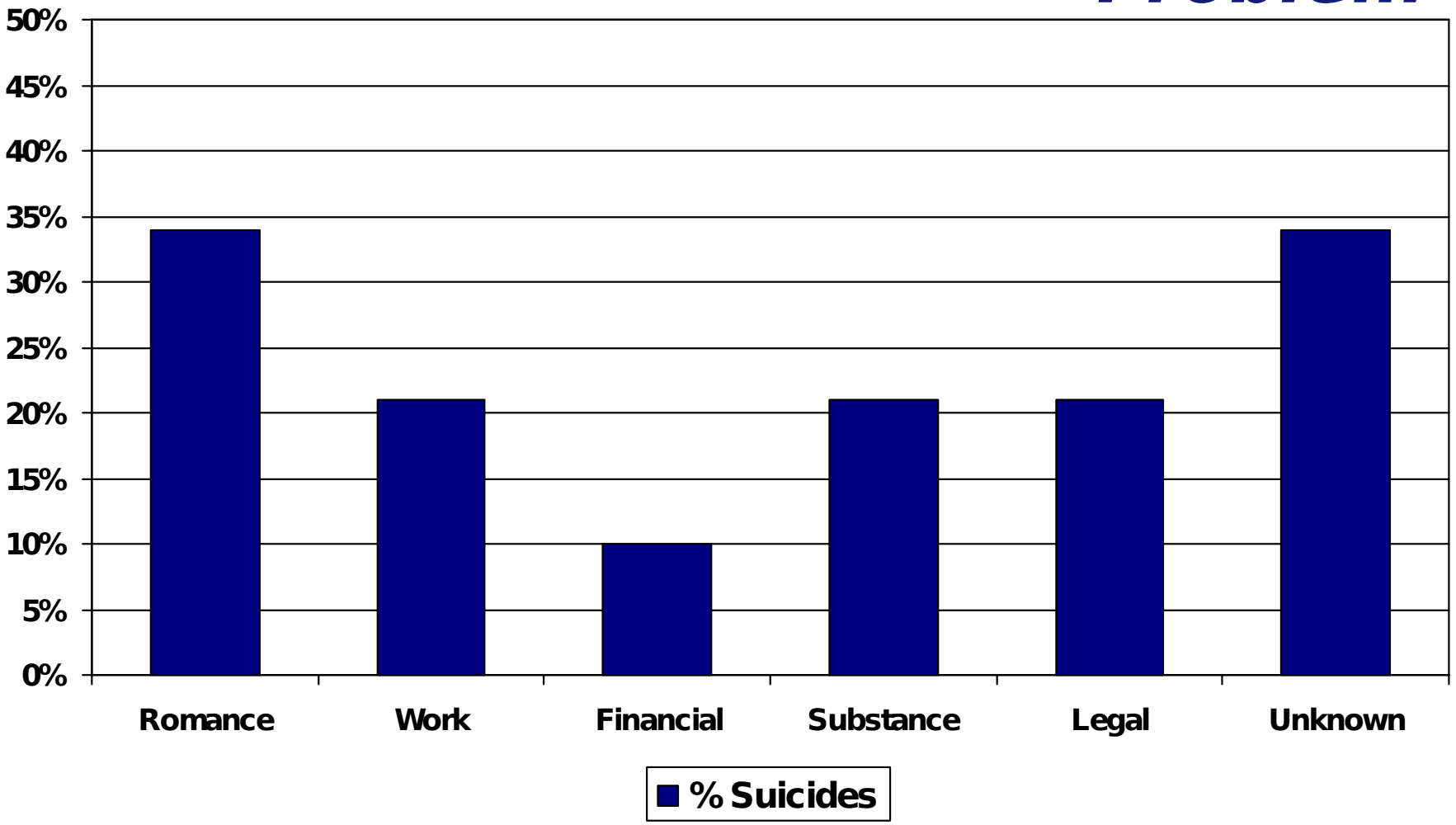
Jan 03 – Dec 03 Percentage of AF Suicides By Types of Problem



Leader's Guide For Managing Personnel in Distress

Welcome to the United States Air Force Leader's Guide for Managing Personnel in Distress

This guide is UNCLASSIFIED and For Official Use Only (FOUO).

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Leader's Guide Overview

- Designed to help leaders
  - Recognize and respond to distress
  - Active duty and civilian unit members
- Guide development
  - 24 month project
  - Working group: Commanders, First Shirts, IDS members, program managers (Family Advocacy; Suicide Prevention; Alcohol/Drug), MAJCOM Behavioral Health Consultants, AF Safety, civilian experts, content

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Organization

- CD, 35 areas of distress
- Each topic
  - Overview
  - Relevant policy
  - Suggested resources
  - References
- Checklist
  - Scenarios
  - Behaviors/signs
  - General support actions

Suicidal Behaviors--Checklist

PRINT

SPECIFIC SITUATIONS	BEHAVIOR/SIGNS	GENERAL SUPPORTIVE ACTIONS
A member displays behaviors suggestive of risk for suicide	☐ Comments that suggest thoughts of suicide ☐ Giving away possessions ☐ Uncharacteristic risk taking (e.g., reckless driving) ☐ Appearing overwhelmed by recent stressor(s) ☐ Displaying significant change in mood ☐ Displaying poor impulse control ☐ Significant change in workplace performance ☐ Seeing situation as hopeless ☐ Obsessing about death, dying, etc. ☐ Making amends or challenging people in an aggressive manner ☐ Acquiring a method for suicide (e.g., buying a handgun) ☐ Rehearsing suicidal acts	☐ Ask "How are you doing?" "Is there anything I can do to help?" ☐ Inquire directly about whether he or she is considering suicide ("Have you had thoughts about wanting to harm or kill yourself?") ☐ Keep them safe--do not leave them alone ☐ Take steps to remove potential means of self-harm including firearms, pills, knives, and ropes ☐ If suicidal thoughts are present, encourage voluntary evaluation at LSSC immediately. Escort person to LSSC. Verify with LSSC that member was evaluated. ☐ If member declined to self-refer, initiate an emergency Commander Directed Evaluation ☐ Involve the Security Forces if agitated or combative ☐ If you need answers to specific questions in order to make a decision i.e., appropriateness for certain duties or retention in the Air Force, request a commander directed evaluation ☐ If hospitalization is required, inquire with LSSC about what assistance is needed (e.g., arranging for child care or pet care)

SPECIFIC SITUATIONS	BEHAVIOR/SIGNS	TAILORED SUPPORT
Behavioral health provider informs you that the member is at increased risk for suicide, but member refuses treatment and does not meet criteria for involuntary hospitalization	☐ Same as above	☐ Communicate a personal desire to see the member return to well-being and to full functioning as soon as possible ☐ Express concern and encourage professional help-seeking ☐ Inquire as to whether the individual has at least one source of support. If needed, try to find an acceptable support person, such as the chaplain or peer ☐ Inquire about barriers of seeking help at LSSC ☐ Remove from duties involving access to weapons, poisons, etc. ☐ Collaborate with LSSC to develop plan to monitor risk and provide support. Frequent follow-up will be important ☐ Take steps to limit access to personal firearms, medications, or other potential means of suicide (work with the member and consult with family members, roommates, etc). Consult with SJA and Security Forces

The member is under suspicion or investigation for a UCMJ violation and shows evidence of suicidality	☐ Talking about suicide ☐ Depressed mood or agitation worsens ☐ Increasing hopelessness	☐ Consider LPSP program ☐ Discuss the nature of the protections with the member
The member is in treatment at LSSC but condition is worsening	☐ Increasingly impaired work performance ☐ Depressed mood or agitation worsens ☐ Increasing social isolation ☐ Worsening personal appearance ☐ Bizarre or unusual behavior ☐ Talking of suicide ☐ Noticeable change or decline after a period of stability	☐ Collaborate with LSSC to develop plan to monitor risk and provide support ☐ Take steps to limit access to personal firearms, medications or other potential means of suicide (work with the member and consult with family members, roommates, etc). Consult with SJA and Security Forces. ☐ Communicate a personal desire to see the member return to well-being and to full functioning as soon as possible

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AFSPP
Air Force Suicide Prevention Program
What Prevents
People From Seeking Help?
BACK
NEXT
exit

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Barriers to Seeking MH

AFSPP | Air Force Suicide Prevention Program

- Denial
- Avoidance
- Fear seeking help will impact job
- Fear chain of command will be contacted
- Example

◀ BACK | NEXT ▶ What Prevents People From Seeking Help exit

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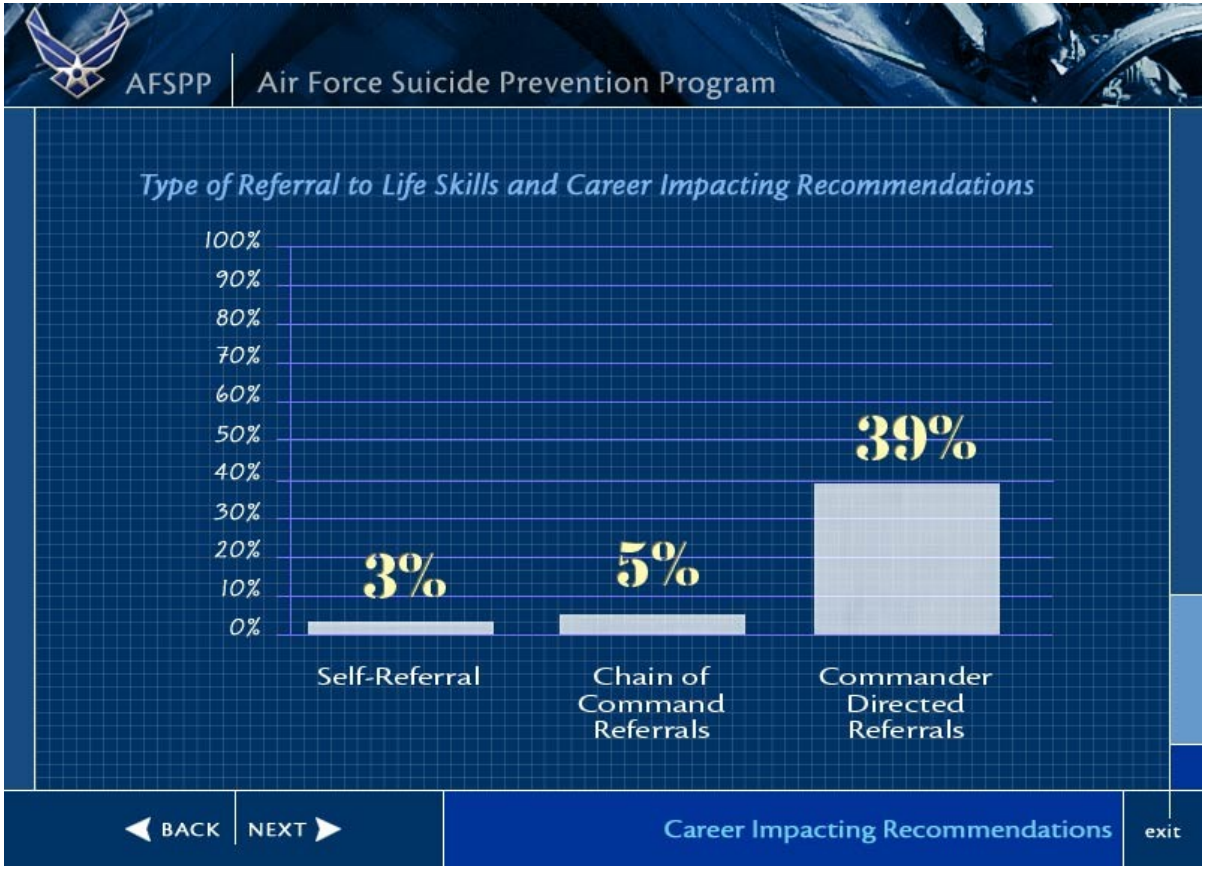
Career Impact of MH Care



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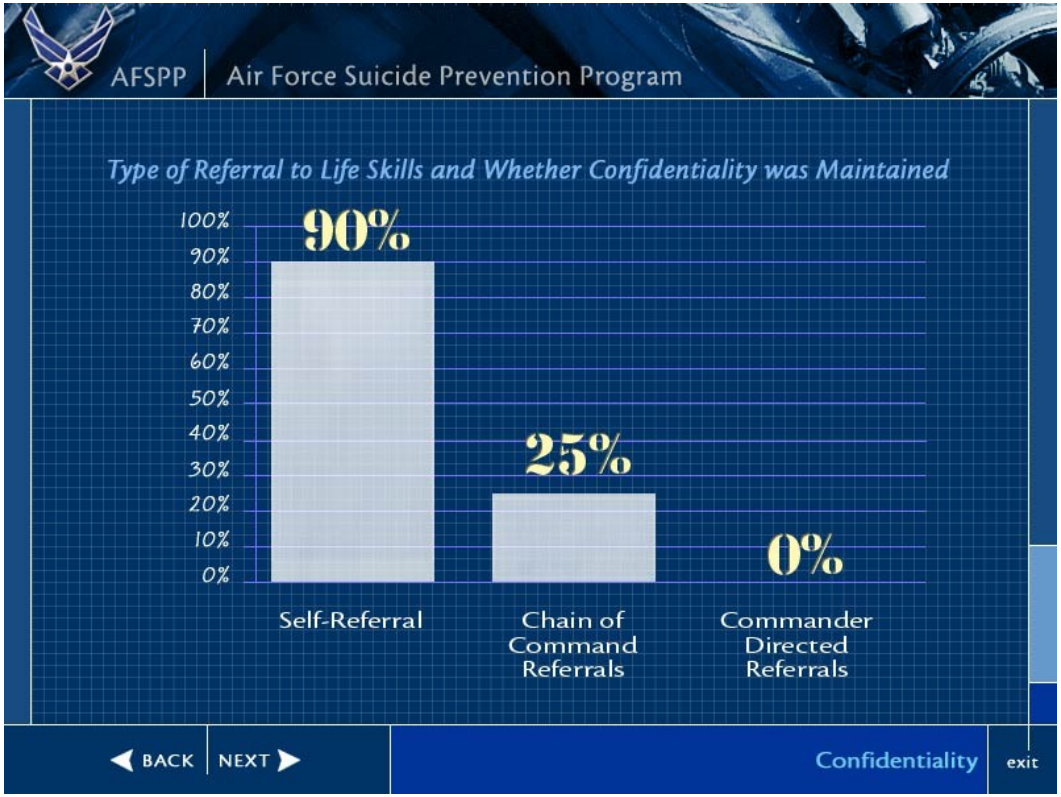
Confidentiality



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NEJM: Barriers to Seeking MH Care

Table 4. Perceived Need for and Use of Mental Health Services among Soldiers and Marines Whose Survey Responses Met the Screening Criteria for Major Depression, Generalized Anxiety, or Post-Traumatic Stress Disorder.*

Outcome	Army Study Groups			Marine Study Group
	Before Deployment to Iraq (N=233)	After Deployment to Afghanistan (N=220)	After Deployment to Iraq (N=151)	After Deployment to Iraq (N=127)
	number/total number (percent)			
Need				
Acknowledged a problem	184/215 (86)	156/192 (81)	104/133 (78)	91/106 (86)
Interested in receiving help	85/212 (40)	75/196 (38)	58/134 (43)	47/105 (45)
Received professional help†				
In past year				
Overall (from any professional)	61/222 (28)	46/198 (23)	56/140 (40)	33/113 (29)
From a mental health professional	33/222 (15)	26/198 (13)	37/138 (27)	24/112 (21)
In past month				
Overall (from any professional)	39/218 (18)	34/196 (17)	44/136 (32)	23/112 (21)
From a mental health professional	24/218 (11)	25/196 (13)	29/136 (21)	16/111 (14)

* Data exclude missing values, because not all respondents answered every question.
† Professional help was defined as help from a mental health professional, a general medical doctor, or a chaplain or other member of the clergy, in either a military or civilian treatment setting.

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Table 5. Perceived Barriers to Seeking Mental Health Services among All Study Participants (Soldiers and Marines).*

Perceived Barrier	Respondents Who Met Screening Criteria for a Mental Disorder (N=731)	Respondents Who Did Not Meet Screening Criteria for a Mental Disorder (N=5422)
	no./total no. (%)	
I don't trust mental health professionals.	241/641 (38)	813/4820 (17)
I don't know where to get help.	143/639 (22)	303/4780 (6)
I don't have adequate transportation.	117/638 (18)	279/4770 (6)
It is difficult to schedule an appointment.	288/638 (45)	789/4748 (17)
There would be difficulty getting time off work for treatment.	354/643 (55)	1061/4743 (22)
Mental health care costs too much money.	159/638 (25)	456/4736 (10)
It would be too embarrassing.	260/641 (41)	852/4752 (18)
It would harm my career.	319/640 (50)	1134/4738 (24)
Members of my unit might have less confidence in me.	377/642 (59)	1472/4763 (31)
My unit leadership might treat me differently.	403/637 (63)	1562/4744 (33)
My leaders would blame me for the problem.	328/642 (51)	928/4769 (20)
I would be seen as weak.	413/640 (65)	1486/4732 (31)
Mental health care doesn't work.	158/638 (25)	444/4748 (9)

* Data exclude missing values, because not all respondents answered every question. Respondents were asked to rate "each of the possible concerns that might affect your decision to receive mental health counseling or services if you ever had a problem." Perceived barriers are worded as on the survey. The five possible responses ranged from "strongly disagree" to "strongly agree," with "agree" and "strongly agree" combined as a positive response.

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Research Recommendations

- **Survey AD members:**
  - **Willingness to seek MH care**
  - **Perceived barriers to MH care**
- **Consider pilot study with enhanced confidentiality/privacy and compare:**
  - **Rates of AD who seek help**
  - **Commander awareness**
  - **Adverse outcomes (alcohol problems, suicidal behaviors, family maltreatment, etc.)**

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Questions?

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